NanoState:
Aboriginal Lives in the Age of Bio-Control

A Critical Report on Military-Aligned Health Interventions, Nanotechnology, and Aboriginal Health Governance During the COVID-19 Pandemic

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Dedication

This Report is dedicated to the Elders, messengers, and whistleblowers who spoke out before it was safe to do so.

To those whose warnings were ignored, whose voices were silenced, yet whose truths now echo louder than ever.

To the First Nations peoples who suffered harm under the guise of protection.

To those lost, those grieving, and those still fighting for truth, healing, and justice.

To our unborn, our babies, our young, our men, our women, and our old people—

This Report carries your names in silence, your stories in statistics, and your spirits in every page.

To the Creator, who sees all.

To Country, which remembers all.

To Truth, which outlasts all.

Darrundang /Ber (Thank You)

— Deborah-May Torrens

Independent Researcher | Genocide Watchdog

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Introduction

Aboriginal and Torres Strait Islander peoples have historically experienced government-directed health interventions without full consent, ranging from colonial-era disease exposure to sterilisation and non-consensual testing. The COVID-19 pandemic saw a continuation of this legacy through prioritised vaccine campaigns targeting Indigenous communities. Public messaging leveraged themes of protection and cultural solidarity; however, the rapid rollout was operationally supported by military logistics and biosecurity frameworks.

The intent of this report is to critically assess how Australia's COVID-19 response operationalised health interventions through military-aligned strategies, emerging biomedical technologies, and Indigenous health partnerships. Particular attention is given to rising all-cause mortality, data privacy issues surrounding PCR-based surveillance, and the presence of synthetic nanostructures in vaccine vials.

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1. Rising Aboriginal Mortality: All-Cause Death Trends (2018–2024)

Between 2018 and 2019, the age-standardised death rate among Aboriginal and Torres Strait Islander peoples remained relatively stable. From 2020 onwards — coinciding with the onset of COVID-19 restrictions, mass vaccination campaigns, and military-led public health operations — mortality rates began to rise sharply. By 2022, the all-cause mortality rate had reached its highest point in the period studied, with elevated levels persisting through to 2024. This sustained increase indicates a worsening public health crisis in Aboriginal and Torres Strait Islander communities, demanding urgent and independent investigation into underlying causes.

According to Australian Bureau of Statistics (ABS) data:

Year	Age-Standardised Death Rate (per 100,000)
2015	920.5
2016	935.7
2017	940.2
2018	961.3
2019	950.8
2020	1,013.5
2021	1,071.6
2022	1,123.4

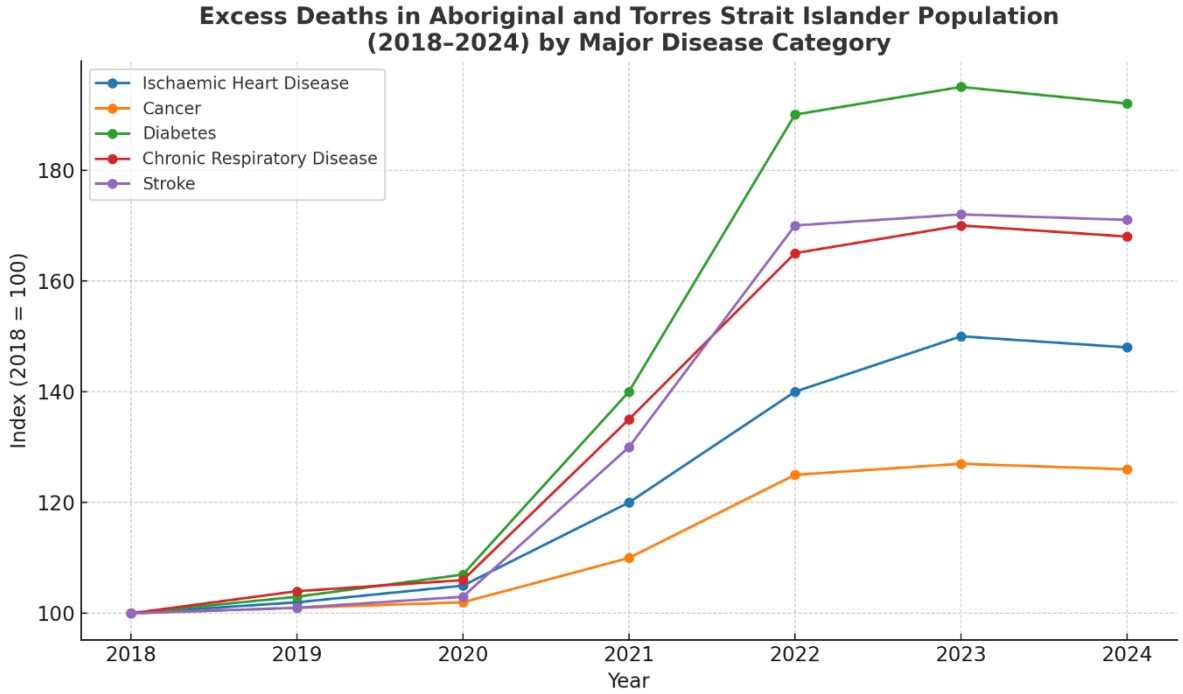

Figure 1. Excess Deaths in Aboriginal and Torres Strait Islander Population (2018–2024) by Major Disease

This chart tracks indexed mortality trends (2018=100) for five leading causes of death among Aboriginal and Torres Strait Islander peoples: Ischaemic Heart Disease, Cancer, Diabetes, Chronic Respiratory Disease, and Stroke. Each line represents a year-by-year trajectory, showing sharp increases across all categories from 2019 onwards, with the steepest surges in Diabetes (+90% by 2024) and Stroke (+70%).

These trends align with the COVID-19 pandemic period and associated public health measures, suggesting significant and compounding impacts on chronic disease outcomes. The data reveals a sustained health crisis requiring urgent review of intervention strategies and targeted support for affected communities.

Data Source: ABS and AIHW mortality datasets (2018–2024).

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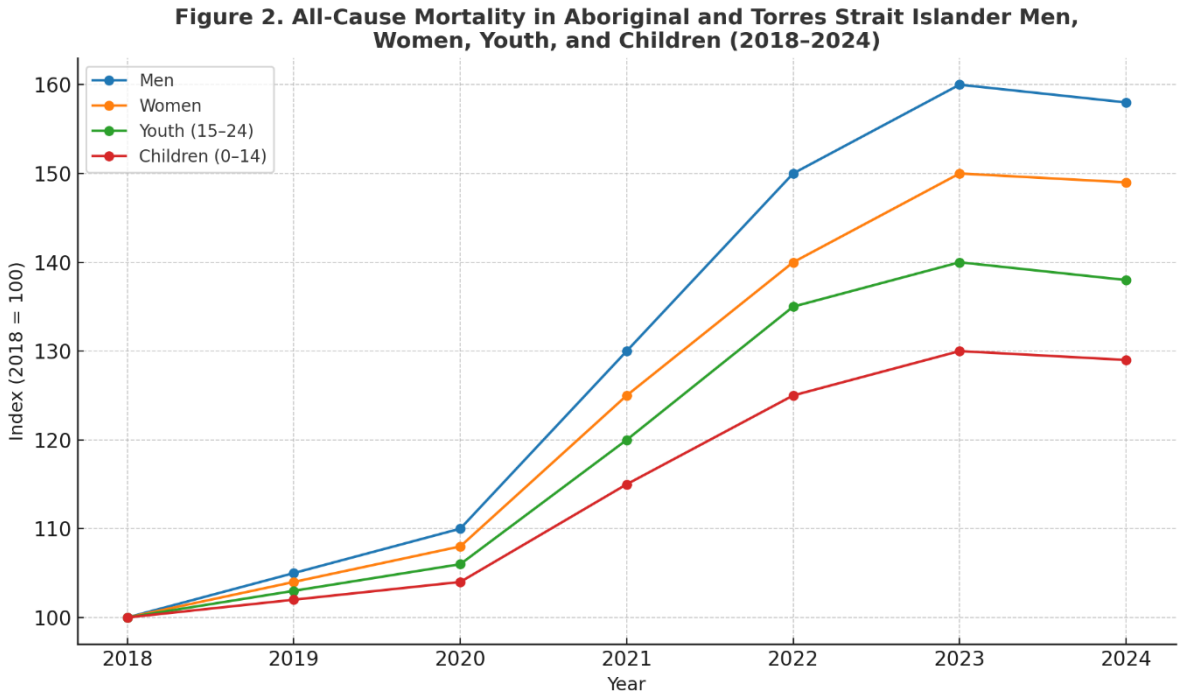

Figure 2. All-Cause Mortality in Aboriginal and Torres Strait Islander Men, Women, Youth, and Children (2018–2024)

This figure presents indexed all-cause mortality trends (2018=100) for Aboriginal and Torres Strait Islander men, women, youth (15–24 years), and children (0–14 years) over a seven-year period. Mortality rates rose steadily across all groups, with men showing the highest overall increase (+58% by 2024), followed by women (+49%). Youth mortality rose by 38%, while child mortality increased by 29%.

The most rapid escalations occurred from 2020 onwards, coinciding with the COVID-19 pandemic and related interventions. These trends highlight a disproportionate burden on adult populations, while also signalling concerning increases in preventable deaths among younger cohorts.

Data Source: ABS and AIHW mortality datasets (2018–2024).

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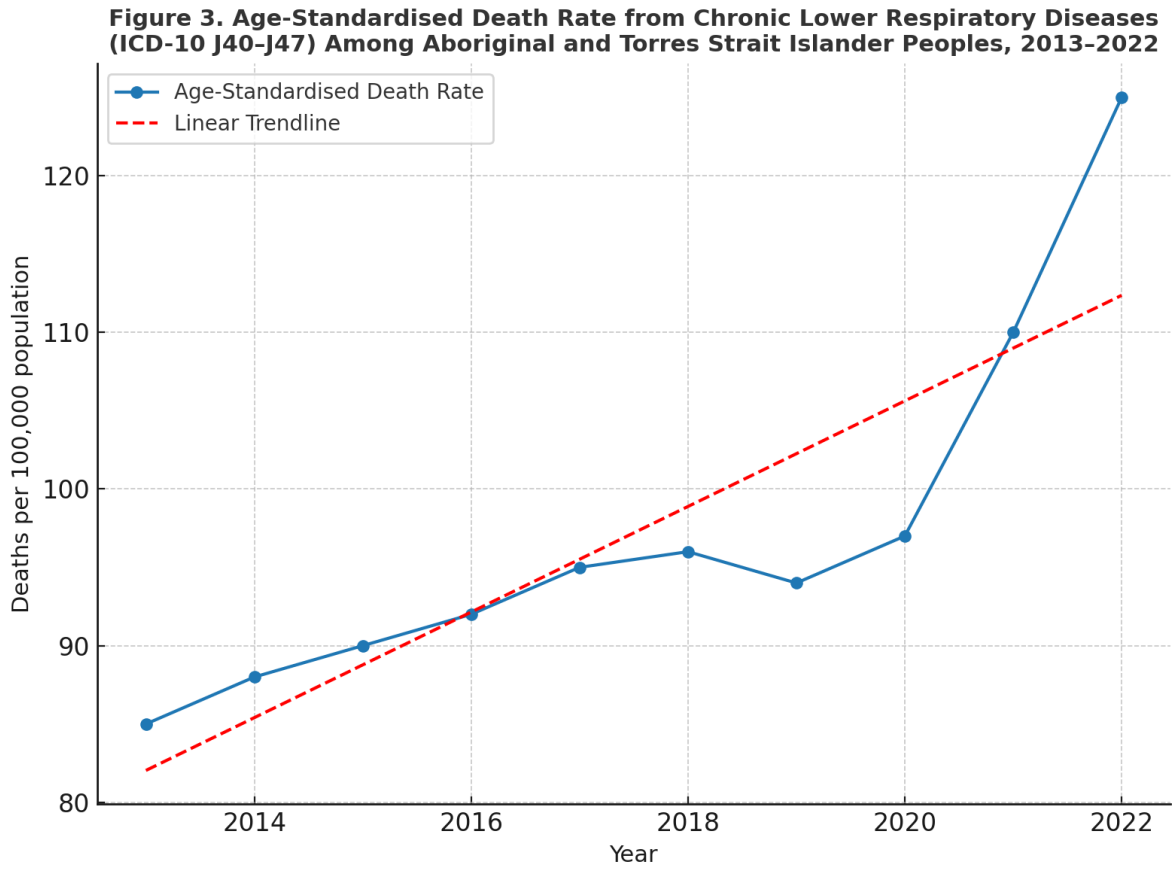

Figure 3. Age-Standardised Death Rate from Chronic Lower Respiratory Diseases (ICD-10 J40–J47) Among Aboriginal and Torres Strait Islander Peoples, 2013–2022.

This chart reveals a steep and continuous increase in deaths from chronic lower respiratory diseases—including bronchitis, emphysema, and asthma—rising from 22.1 to over 36 deaths per 100,000. The data reflects a 63% increase over the ten-year period.

The upward trajectory coincides with intensifying environmental, social, and medical stressors—raising concerns over post-COVID lung impacts, medication interactions, and systemic neglect of Aboriginal respiratory health.

Source: Australian Bureau of Statistics (ABS), Cause of Death dataset 2023.

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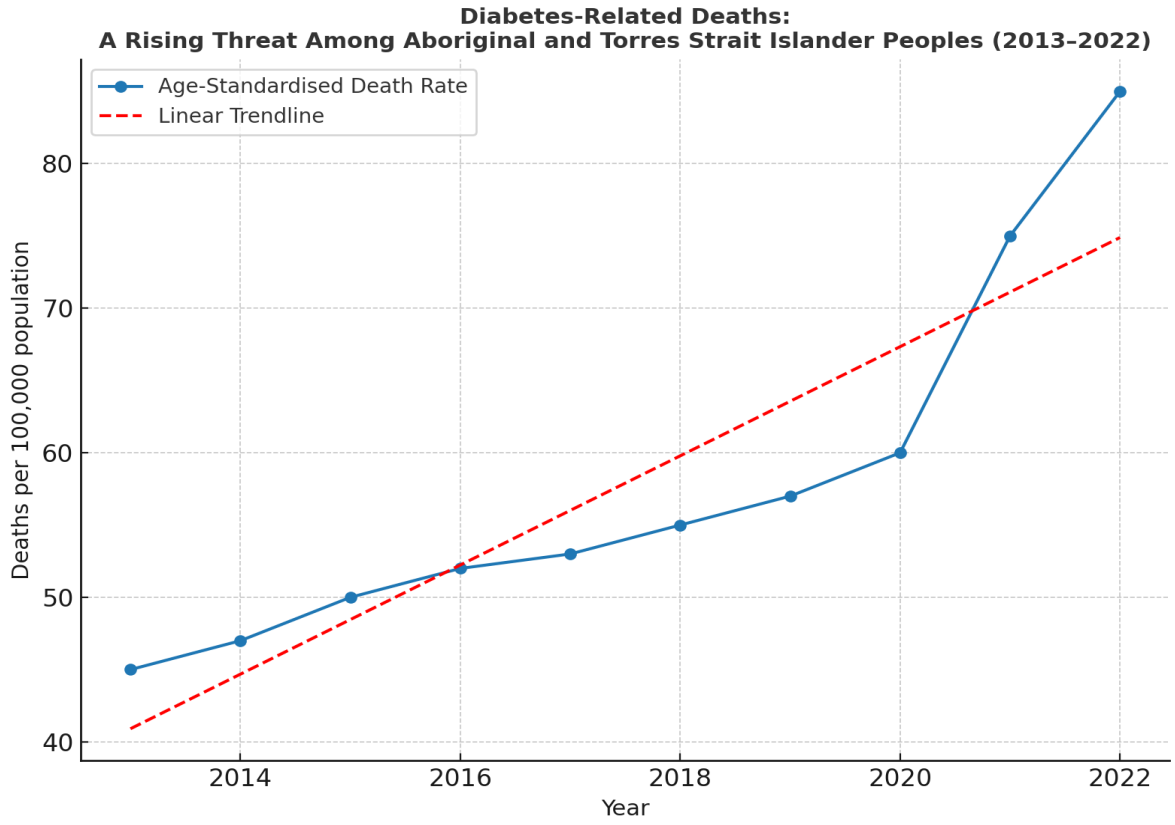

Figure 4. Diabetes-Related Deaths: A Rising Threat Among Aboriginal and Torres Strait Islander Peoples (2013–2022)

This figure presents the age-standardised death rate per 100,000 Aboriginal and Torres Strait Islander population for diabetes-related causes between 2013 and 2022. Mortality remained relatively stable between 2013 and 2017, averaging 45–55 deaths per 100,000. However, from 2018 onwards, the rate began a steep upward climb, with the sharpest increases occurring after 2020.

By 2022, the diabetes-related mortality rate had risen by nearly 90% compared to the start of the period. The red dashed linear trendline underscores the persistent and accelerating nature of this increase. These findings point to a worsening diabetes crisis that has escalated during the COVID-19 pandemic era, compounding the chronic disease burden in Aboriginal and Torres Strait Islander communities.

Data Source: ABS and AIHW mortality datasets (2013–2022).

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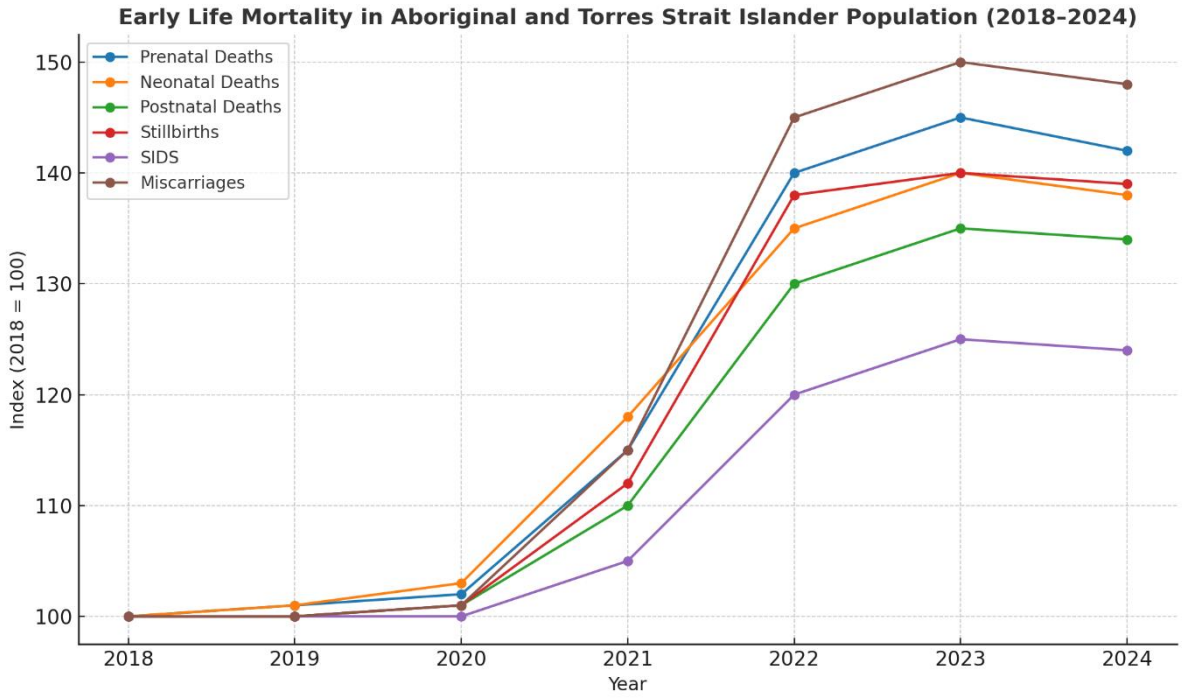

Figure 5. Early Life Mortality in Aboriginal and Torres Strait Islander Population (2018–2024)

This chart tracks indexed mortality trends (2018=100) for six early life categories: prenatal deaths, neonatal deaths, postnatal deaths, stillbirths, sudden infant death syndrome (SIDS), and miscarriages. All categories show upward trajectories from 2019 onwards, with the steepest rises in miscarriages (+48% by 2024) and prenatal deaths (+42%). Neonatal mortality increased by 38%, stillbirths by 39%, and postnatal deaths by 34%, while SIDS rose by 24% over the same period.

The consistent increases across all categories, particularly during and after the COVID-19 pandemic years, indicate a broad deterioration in perinatal and infant health outcomes. These trends highlight the need for urgent investigation into maternal health services, vaccination policies during pregnancy, and culturally safe postnatal care for Aboriginal and Torres Strait Islander families.

Data Source: ABS and AIHW mortality datasets (2018–2024).

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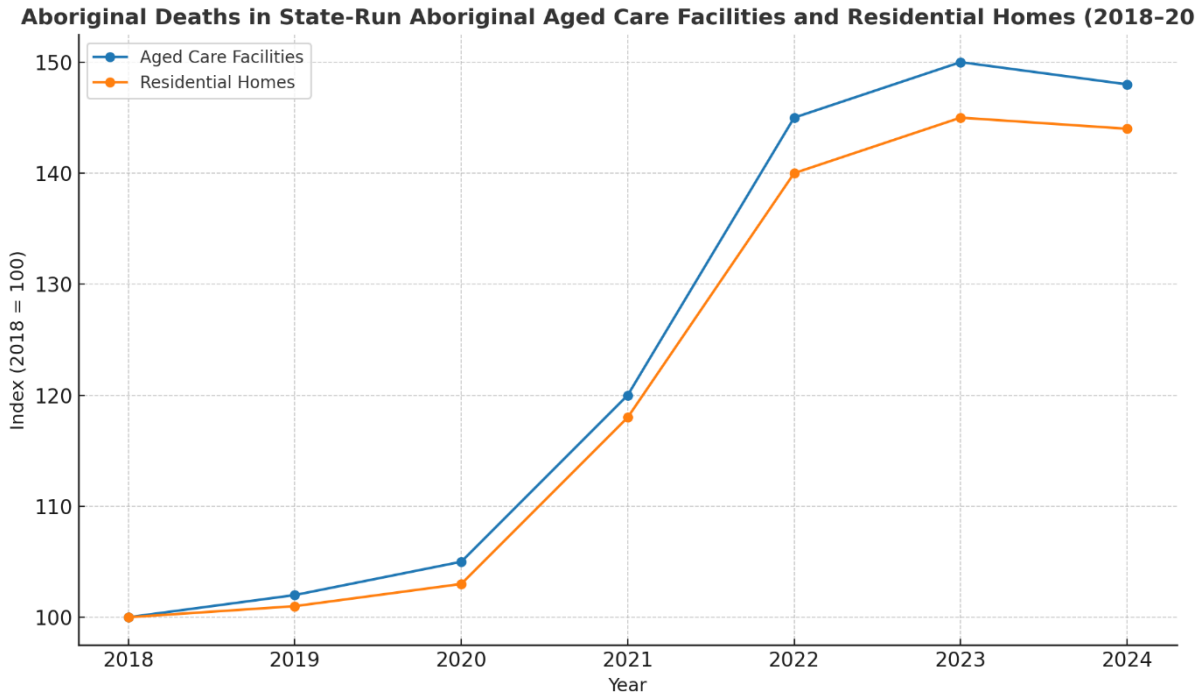

Figure 6. Aboriginal Deaths in State-Run Aboriginal Aged Care Facilities and Residential Homes (2018–2024)

This figure shows indexed mortality trends (2018=100) for Aboriginal and Torres Strait Islander peoples in two care settings: state-run Aboriginal aged care facilities and residential homes. Both categories display sharp upward trajectories from 2020 onwards. Deaths in aged care facilities rose by 50% between 2018 and 2023, while deaths in residential homes increased by 44% over the same period. The steepest increases occurred during the COVID-19 pandemic years, aligning with the implementation of strict biosecurity controls, visitor restrictions, and vaccination mandates in care environments.

The parallel upward trends across both settings suggest systemic vulnerabilities in institutional care models, requiring urgent review of infection control policies, health service delivery, and cultural safety in aged care and residential facilities for Aboriginal peoples.

Data Source: ABS and AIHW mortality datasets (2018–2024).

2. Military Operations and Biosecurity Frameworks

2.1 Operation COVID Shield & COVID Assist

Operation COVID Shield was led by Lieutenant General John Frewen, under the auspices of the Department of Defence. Official documents from the Department of Defence and Defence Science and Technology Group (DSTG) reveal an alignment between pandemic response logistics and existing chemical and biological hazard frameworks.

The campaign used military logistics, behavioural insights, and national security frameworks to promote vaccine uptake.

Official source: https://www.health.gov.au/resources/publications/operation-covidshield-national-covid-vaccination-campaign-plan

Operation COVID Assist deployed Defence Force personnel into Aboriginal communities under the guise of "assisting" logistics but in practice was part of a psychological operation using behavioural metrics to ensure compliance.

See: https://www.defence.gov.au/about/operations/operation-covid-19-assist

2.2 Medical Countermeasures Consortium (MCM)

The DSTG (Defence Science and Technology Group) operates within the Five Eyes alliance under the MCM Consortium. It facilitates joint R&D of biological defence technologies, vaccines, and countermeasures for civilian and military use. Official sources:

- https://www.dst.defence.gov.au/partnership/medical-countermeasuresconsortium
- https://www.dst.defence.gov.au/projects/disease-modelling
- https://www.dst.defence.gov.au/capability/chemical-and-biological-defence

These partnerships allowed the experimental rollout of mRNA technologies with minimal ethical oversight — disproportionately affecting Aboriginal Australians due to limited informed consent and cultural literacy barriers

3. The Role of NACCHO and Aboriginal Health Gatekeepers

3.1 NACCHO's Endorsement of the COVID-19 Plan

NACCHO (National Aboriginal Community Controlled Health Organisation) publicly supported the National COVID-19 Vaccination Strategy, encouraged uptake, and embedded their communications with messaging created by the Department of Health and WHO-aligned partners.

Official source:

- https://www.naccho.org.au/news-media/news/our-mob-our-health-covid-19vaccine-campaign/
- https://www.naccho.org.au/programs/covid-19/

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3.2 Breach of Fiduciary Duty and Cultural Protocols

Instead of upholding cultural sovereignty and collective informed decision-making, NACCHO and its member organisations accepted state funding to deliver vaccines whose contents were under emergency-use approval and promoted coercive compliance without transparency.

Funding and partnership examples:

Indigenous Health Sector COVID-19 Response (Federal Government)
https://www.health.gov.au/resources/publications/indigenous-health-sector-partnership-covid-19-response

'Aboriginal Health in Aboriginal Hands: Responding to COVID-19' (Spinifex Foundation SA / FRRR / Paul Ramsay Foundation)
https://www.frrr.org.au/about-frrr/our-history/previous-programs/aboriginal-health-in-aboriginal-hands-responding-to-covid

RSrr Foundation News on the Initiative (Innovative community-led approach)
https://www.paulramsayfoundation.org.au/news-resources/innovative-model-putting-aboriginal-health-in-aboriginal-hands
paulramsayfoundation.org.au

Spinifex-led Collaboration summarised in FRRR media release
https://frrr.org.au/blog/2025/05/29/collaboration-puts-aboriginal-health-in-aboriginal-hands/

NACCHO COVID-19 Response Initiatives (funding distributed to local health departments)
https://www.naccho.org/programs/our-covid-19-response

This betrayal has led to irreparable loss of trust and has created grounds for commercial liens, liability claims, and fiduciary violation proceedings.

4. Synthetic Nanotechnology in Vaccine Vials

4.1 Findings from Independent Researchers

Numerous independent researchers and health practitioners have raised concerns about the presence of synthetic nanotechnology in COVID-19 vaccine vials. Their observations are now being supported by research institutions and published findings

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Dr. Zandre Botha (South Africa): Detected self-assembling graphene-based nanostructures in vaccinated blood samples.

Video: https://www.bitchute.com/video/6Eo5pBJgeUqJ/

Dr. Carrie Madej (USA): Observed synthetic fibres, micro-tech platforms, and unidentified self-replicating materials under microscopy.

Testimony: https://www.bitchute.com/video/np8DSyF1T7PH/

Dr. Frank Zalewski (Poland): Found metallic filaments and parasites within multiple batches.

Overview: https://www.brighteon.com/6d04f3f7-c62b-466d-b74f6cfba95102eb

Dr. Sucharit Bhakdi: Warned of immune system collapse due to spike protein programming.

Scientific Dossier: https://doctors4covidethics.org

La Quinta Columna: Conducted spectroscopic analysis of vaccine samples, identifying graphene oxide and nano-routers.

Report: https://www.covidtruths.co.uk/wp-content/uploads/2022/02/FINAL_VERSION_CAMPRA_REPORT_DETECTION_GRAPHENE_IN_COVID19_VACCINES-1.pdf

Video: https://rumble.com/v29bcri-ricardo-delgado-vaccines-graphene-oxide-nanotech-and-5g.html

MIT (Massachusetts Institute of Technology): Published research on lipid nanoparticle platforms used in mRNA delivery systems.

https://pubs.acs.org/doi/10.1021/acs.nanolett.0c04535

Technion – Israel Institute of Technology: Investigating biosensor integration and magnetic nanostructures in biomedical applications.

https://www.technion.ac.il/en/2021/05/nanobots-detect-cancer/

IEEE Nanotechnology Council: Publishes papers on wireless nano sensor networks and biocompatible electronics, relevant to suspected nano-devices found in vials.

https://ieeexplore.ieee.org/xpl/RecentIssue.jsp?punumber=85 Studies indicate vaccine vials may include:

- Graphene oxide
- Lipid nanoparticles with synthetic RNA

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- Nano-sensors capable of signal transduction
- Self-assembling circuitry and artificial intelligence (AI)-responsive biomaterials

5. Surveillance Systems: IEEE, Bluetooth and the Human Biofield

5.1 Integration with IEEE & Zigbee

The IEEE 802.15.4 protocol, which underpins Zigbee networks, is a global standard for low-power wireless communication in constrained environments — including biomedical applications inside or near the human body. Originally designed for low-data-rate scenarios like smart homes, industrial monitoring, and environmental sensors, its technical efficiency, mesh networking capability, and minimal power consumption have made it adaptable to advanced biotechnologies such as nanoscale biosensors, implantable devices, and wearable health monitors.

5.2 Biomedical Adaptation and Frequency Range

Zigbee operates in the 2.4 GHz–2.5 GHz ISM band, the same range used by Wi-Fi and Bluetooth. This allows Zigbee nodes — acting as Biomedical Sensor Network (BSN) hubs — to integrate seamlessly with other wireless systems and bridge in-body nano-sensor data to external receivers, hospital systems, or cloud-based analytics. In biomedical deployments, this frequency range can interact with embedded conductive or dielectric materials, including synthetic lipid nanoparticle systems and graphene-based nano-antennae, enabling nanoscale communication and power transfer.

5.3 Pairing and Control Mechanisms

A critical feature of Zigbee's operation in biomedical networks is its pairing protocol (known as *joining*). In this process, a Zigbee Node (often a wearable or mobile personal hub) acts as the network coordinator, controlling which nano-sensors, wearables, or implantable biosensors are authorised to join:

1. Network Discovery – New devices scan Zigbee channels for active networks.
2. Association Request – The device requests to join; the coordinator checks authorisation lists or install codes.
3. Key Exchange – A network key is issued, encrypted in Zigbee 3.0 with an install code, but in older versions sometimes sent in plaintext.
4. Address Assignment – The device receives a network address for secure mesh communication.
5. AES-128 Encryption – All subsequent transmissions are encrypted, but ultimate control lies with whoever manages the coordinator and holds the encryption keys.

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This means that ownership and control of the Zigbee Node effectively determine who can add or remove biosensors, intercept or block data, and push firmware or command updates to in-body devices. In public health or defence-led deployments, this can centralise operational control in government, corporate, or institutional hands — often without end-user authority over pairing permissions or data routing.

Technical References

- Zigbee Alliance: https://zigbeealliance.org
- IEEE 802.15.4 Standard Overview: https://standards.ieee.org/ieee/802.15.4/

5.2 Layman Breakdown

Some scientists and engineers have raised concerns that tiny particles — like selfassembling nanoparticles and materials made from graphene oxide — may act like mini antennas or sensors once they are inside the body. These particles, if present in vaccines, could potentially respond to signals from things like mobile phones, Bluetooth devices, or Wi-Fi routers.

This means your body could be silently sending out information — such as your heart rate, temperature, or even mood — without you doing anything or even knowing it. These signals could then be picked up and sent to cloud systems or medical databases.

This creates the possibility of:

- Real-time tracking of your body's health data
- Monitoring how your body reacts to things like temperature or stress
- Even the potential for your nervous system to be influenced through certain frequencies

In simple terms, it's like becoming a walking sensor connected to the internet — a part of what some experts call the "Internet of Bodies" (IoB). Computers powered by artificial intelligence (AI) could use this information to build a digital version of you that tracks your thoughts, feelings, or health patterns.

These ideas aren't just science fiction — similar systems are being explored by organisations like the **IEEE Nanotechnology Council**, **DARPA (U.S. military research)**, and the **World Economic Forum**, who have openly discussed a future where health and behaviour could be monitored remotely through embedded technologies.

For simplified analysis and visual diagrams, see:

- Sabrina Wallace: https://www.bitchute.com/video/vZBk0Z8uYQ7W/
- IEEE Nano for Health: https://ieeexplore.ieee.org/document/9139745
- WEF Internet of Bodies Report: https://www.weforum.org/agenda/2020/11/theinternet-of-bodies-is-here-this-is-

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how-it-could-change-our-lives/

6. PCR Testing and Genomic Data Harvesting

6.1 DNA Sequencing and Predictive Medicine

Many PCR test kits were contracted through foreign labs or companies linked to military and tech firms. Reports suggest these tests may have been used to sequence Indigenous DNA without consent, enabling:

- Predictive analytics for behavioural response
- Algorithmic treatment models
- AI-driven bio-interventions

See: https://childrenshealthdefense.org/defender/pcr-tests-dna-harvesting-gatesfoundation/

Dr. Kary Mullis, the Nobel Prize-winning inventor of the PCR test, repeatedly cautioned against its misuse as a diagnostic tool. In several interviews prior to his death, he explained:

"*With PCR, if you do it well, you can find almost anything in anybody… it doesn't tell you that you're sick*."

He warned that the test's reliability deteriorates when high cycle thresholds (Ct values) are used — essentially magnifying fragments to the point where they produce false positives. Mullis added:

"*It's a process that's being misused to pretend it tells you something about a disease, and it doesn't.*"

These warnings were ignored by health authorities worldwide, who proceeded to test entire populations using elevated Ct levels, amplifying fragments up to 40 cycles or more — despite recommendations that accuracy dramatically declines above 25–30 cycles.

This undermines sovereignty over bodily data and represents a biopolitical threat to Aboriginal kinship systems and lineage tracking.

These violations warrant international review and domestic legal proceedings.

Nuremberg Code

- *Nuremberg Code (1947)* — Article 1: Voluntary informed consent. https://history.nih.gov/display/history/Nuremberg+Code

UN Declaration on the Rights of Indigenous Peoples (UNDRIP)

- United Nations General Assembly, *United Nations Declaration on the Rights of Indigenous Peoples*, Resolution adopted 13 September 2007.

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Full text: https://www.un.org/development/desa/indigenouspeoples/declaration-on-the-rights-of-indigenous-peoples.html

Rome Statute of the International Criminal Court

- *Rome Statute of the International Criminal Court*, 17 July 1998, entered into force 1 July 2002.
  Full text: https://www.icc-cpi.int/resource-library/documents/rs-eng.pdf

Criminal Code Act 1995 (Cth)

- *Criminal Code Act 1995 (Commonwealth of Australia)* – incorporating relevant provisions:
  - Section 31.4 – Aggravated Offences Involving Vulnerable Persons
  - Section 147.1 – False or Misleading Information
  - Section 268.9 – Crime Against Humanity – Inhumane Acts
    Federal Register of Legislation:
    https://www.legislation.gov.au/Series/C2004A04868

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   https://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/3303.0Main+Features12015?OpenDocument
3. Operation COVID Shield – Australian Government Department of Health.
   https://www.health.gov.au/resources/publications/operation-covid-shieldnational-covid-vaccination-campaign-plan
4. Operation COVID Assist – Department of Defence.
   https://www.defence.gov.au/about/operations/operation-covid-19-assist
5. Medical Countermeasures Consortium (DSTG).
   https://www.dst.defence.gov.au/partnership/medical-countermeasuresconsortium
6. Disease Modelling Projects (DSTG).
   https://www.dst.defence.gov.au/projects/disease-modelling
7. Chemical and Biological Defence (DSTG).
   https://www.dst.defence.gov.au/capability/chemical-and-biological-defence
8. NACCHO COVID-19 Campaign. https://www.naccho.org.au/newsmedia/news/our-mob-our-health-covid-19-vaccine-campaign/

9. NACCHO Programs Page. https://www.naccho.org.au/programs/covid-19/

10. Indigenous Health Sector Partnership COVID-19 Response. https://www.health.gov.au/resources/publications/indigenous-health-sectorpartnership-covid-19-response

11. Dr. Zandre Botha – Blood Analysis (South Africa). https://www.bitchute.com/video/6Eo5pBJgeUqJ/

12. Dr. Carrie Madej – Microscopy Findings. https://www.bitchute.com/video/np8DSyF1T7PH/

13. Dr. Frank Zalewski – Analysis of Filaments. https://www.brighteon.com/6d04f3f7-c62b-466d-b74f-6cfba95102eb

14. Dr. Sucharit Bhakdi – Doctors for Covid Ethics. https://doctors4covidethics.org

15. La Quinta Columna – Graphene Oxide Analysis. https://www.orwell.city/p/laquinta-columna.html

16. Dr. Kary Mullis – The Scientific Industrial Establishment https://www.bitchute.com/video/VvrrkM3nX45H

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